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Authorization to Release Protected Health Information

Name Last	First	Middle	Maiden
Address Street	**City**	**State**	**zip**
Social Security #	**Birthdate**		

Release Information From	Release Information To
	Dehen Chiropractic, LTD Dr. Mark D. Dehen 1706 Lor Ray Drive North Mankato MN 56003 P:(507)388-7744 F:(507)388-8001

Purpose of Release

	Treatment/Continued Care		Personal		Legal purposes
	Application for Insurance		Disabiltiy determination		Payment of insurance claim
	Other				

Information To Be Released

	Spinal X-rays(actual films)		MRI Report
	Spinal X-rays Report of Findings		CT Report
	X-rays		Lab Results
	Other(specify information to be released in the space below)		

I understand the information to be released may include records related to behavior and/or mental health care, alcohol and drug abuse treatment, HIV/Aids, and genetics. This authorization may be revoked at any time except to the extent that action has been taken in reliance upon it. Revocation must be made in writing to the provider/facitlity will not condition treatment on whether I sign the authorization. **I may be charged for copies in accordance with state law.** Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal law.

This authorization will expire one year from the date of signing unless indicated an earlier date or event here:

ATTENTION: This is a legal document. Please read carefully. By signing, you agree that you understand and accept the terms on this form.

If the patient is 18 years of age or older, the patient must sign and date the form.

If the patient is 18 years of age or older and is incapable of signing,
a legally authorized substitue may sign and date the form.
Please indicate your legal authority and include documentation of your relationship:

Legal Guardian or Conservator | Health Care Agent(Health Care Power of Attorney

If the patient is 17 years of age or younger,
the patient's parent or legal guardian must sign and date the form, unless an exception exists under state or federal law. Please indicate your relationship:

Parent | Legal Gaurdian

Signature (Required) **Date Signed** (Required)(mm,dd,yyyy)

Printed Name of Person Signing (If Not Patient)